

most cases of AIDS are reported from areas where histoplasmosis is not a prevalent infectious disease problem.<sup>18</sup>

Gastrointestinal tract involvement occurs in up to 75% of cases of disseminated histoplasmosis.<sup>14,19</sup> Nevertheless, clinically obvious gastrointestinal involvement is infrequent and oral lesions are far more common than colonic manifestations. In cases where the colon is involved, the lesion usually begins as an elevated plaque, with progression to a localized granulomatous ulcer. Uncommonly, such foci will assume a different pattern of growth, resulting in a mass that can simulate carcinoma as a constricting ("apple core") lesion<sup>19</sup> or, as in our patient, as a fungating intraluminal tumor.

The presence of autoimmune thrombocytopenia in this patient is an interesting finding. Morris and associates have described patients with AIDS who were also noted to have thrombocytopenia and elevated platelet IgG values.<sup>20</sup> *Histoplasma*-induced autoimmune thrombocytopenia has likewise been reported.<sup>21</sup> Whether AIDS or *Histoplasma*-induced thrombocytopenia is important in this case cannot be determined.

Although cases of hemolytic and hypoproliferative anemia have been reported in patients with Kaposi's sarcoma,<sup>22,23</sup> anemia is not recognized as a common manifestation of AIDS per se. Our patient had an inadequate marrow response to continued postoperative gastrointestinal blood loss. His serum iron and iron-binding capacity are consistent with what has been recognized as "anemia of chronic inflammation."

Untreated, the mortality of disseminated histoplasmosis in patients who do not have this syndrome has been as high as 83%.<sup>24</sup> The efficacy of therapy with amphotericin B is well established, although total dosages must exceed 2 grams.<sup>25</sup> Ketoconazole has been effective in selected cases of disseminated histoplasmosis and its use is associated with far less toxicity than for amphotericin B.<sup>26</sup> This new imidazole derivative would have been particularly advantageous for our patient, given his increased likelihood for new fungal infections that would require additional amphotericin B. Unfortunately, ketoconazole's efficacy for treatment of disseminated histoplasmosis in immunosuppressed patients has been disappointing.<sup>27,28</sup>

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## Factitious Hematuria and Self-Induced *Candida albicans* Fungemia

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PATIENTS WITH FACTITIOUS disorders are characterized by their conscious production of spurious historical, physical or laboratory data for no apparent reason other than to assume the patient role.<sup>1</sup> These patients represent a diverse psychiatric group and may simulate a wide variety of medical problems. In this report we describe a case of a patient with factitious hematuria, fever and *Candida albicans* fungemia and review the diagnosis and management of factitious disorders.

(Gordon GH, Chrys R: Factitious hematuria and self-induced *Candida albicans* fungemia. West J Med 1985 Aug; 143:246-249)

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## Report of a Case

The patient, a 23-year-old man, presented to an emergency room with a two-day history of right lower quadrant pain and gross hematuria accompanied by nausea, vomiting and mild dysuria. He stated that his right kidney had been "ruptured" during a parachute jump while he was serving military duty in 1978, producing transient hematuria. He also gave a history of operations in 1979 and 1982 to "straighten a kinked ureter" on the right and an appendectomy in 1980. There was no history of nephrolithiasis, dysuria, fever or recent trauma.

On physical examination he was in mild distress, with an oral temperature of 36.6°C (97.3°F), pulse 74 beats per minute, blood pressure 100/70 mm of mercury and respiratory rate 16. Positive physical findings were limited to the abdomen. Two midline surgical scars extended from the umbilicus to the pubis and an appendectomy scar was present. Bowel sounds were normal. There was tenderness to light palpation in the right lower quadrant without guarding or rebound tenderness and he had a 3-cm right inguinal hernia that was easily reducible. Results of rectal and genital examinations were normal and there was no tenderness at the costovertebral angle. Laboratory data included an analysis of urine showing erythrocytes too numerous to count, 0 to 2 leukocytes per high power field, 1+ protein and no bacteria. Serum glucose level, electrolytes, complete blood count, prothrombin time, partial thromboplastin time, platelet count and blood urea nitrogen and serum creatinine levels were all normal. X-ray films of the chest and abdomen also were normal.

The patient was admitted to the Urology Service where an intravenous pyelogram showed an ectopic and malrotated right pelvic kidney with mild pyelocaliectasis. The right ureter was short but of normal caliber, and the left kidney was normal. Cystoscopy and retrograde pyelography failed to show a source of bleeding. On renal angiography there were double renal arteries on both sides but no other abnormalities. A urine specimen obtained by catheterization contained no blood. The patient's abdominal pain continued and he requested frequent parenteral administration of narcotics. Several institutions where he claimed to have received treatment had no record of his care. Factitious hematuria was suspected, and the nursing staff was instructed to observe the patient urinate.

On the seventh through the tenth hospital days, oral temperature elevations were recorded ranging from 39°C (101.7°F) to 40.7°C (104.7°F). Temperature elevations were unaccompanied by tachycardia or leukocytosis. Cultures of blood and urine specimens were carried out and empiric antibiotic therapy for a presumptive urinary tract infection was begun. By the 18th hospital day the patient's hematuria and fever had resolved, but culture of four of eight blood specimens obtained on three separate days during his febrile episodes grew *Candida albicans*. The patient was transferred to the Medical Service where a careful physical examination showed no evidence of fungal endocarditis or disseminated fungal infection. One day following transfer, the patient complained of a stiff neck and was found to have an oral temperature of 38.6°C (101.0°F). A lumbar puncture was done that yielded clear fluid with a glucose level of 72 mg per dl, a protein value of 41 mg per dl and no cells. Cultures of

two more blood specimens taken on the day of transfer again grew *C. albicans*. Cultures of several urine and throat specimens showed no growth of *Candida*, and an echocardiogram, gallium scan and computed tomographic study of the abdomen failed to show a focus of infection.

On the 22nd hospital day, acting on information received from a roommate, the patient's personal belongings were searched and several tuberculin syringes and a vial of milky-white substance were recovered. Laboratory analysis showed that the substance was magnesium-containing antacid that grew *C. albicans* on culture. When the patient was confronted with these findings, he confessed to injecting the substance intravenously through the antecubital fossa. He said he did not know that the antacid was contaminated and that he injected himself to relieve pain and to draw attention to his inguinal hernia, which he wanted repaired. After the vial and syringes were removed from the bedside, the patient's fevers disappeared and eight subsequent blood cultures were negative for *C. albicans*.

Psychiatric consultation was obtained, and the patient was transferred voluntarily to the Psychiatry Service. He stated that his parents had divorced when he was 6 months old and that he had been raised by his father, in whom a chronic illness developed following radiation exposure during military duty. The patient believed that his pelvic kidney and inguinal hernia were genetic defects related to his father's radiation exposure. He admitted that he had abused drugs intravenously in the past and recently had been released from prison in Texas after serving a one-year term for passing bad checks. He reported having difficulty reintegrating into society and requested that his hospital discharge be delayed until he could make plans for living outside the hospital. It was discovered that the patient had been admitted to hospital with hematuria in the San Diego Veterans Administration Medical Center one month before admission but had used a false social security number and military service dates. Results of psychological testing indicated poor insight and impulse control and a tendency to somatize anxiety. He became increasingly hostile and noncompliant on the Psychiatry Service and was discharged on the 58th hospital day with a psychiatric diagnosis of borderline personality disorder with histrionic and schizoid features, and adjustment disorder with anxious and depressed mood.

## Comment

### Factitious Disorders

The incidence of factitious disorders, particularly among outpatients, is unknown; however, 41 inpatient cases were reported from a teaching hospital during a ten-year period.<sup>2</sup> Patients with factitious disorders may present with symptoms and signs referable to any organ system. The complaints may be either dramatic and urgent or complex and subtle. As in the case reported here, the presence of a preexisting pathologic condition or a self-induced pathophysiologic state can make a spurious history seem more credible. Patients may also present with several simultaneous factitious disorders.<sup>2-5</sup>

Gross hematuria with or without renal colic is a common factitious disorder and may be produced by adding blood to urine after voiding or by traumatizing the urethra.<sup>3,4,6-10</sup> Some patients can actually simulate the roentgenographic appearance or passage of renal calculi.<sup>9,10</sup> Although ectopic or

malrotated kidneys may be associated with abdominal or flank pain, pyuria, proteinuria and recurrent urinary tract infections,<sup>11</sup> it seems likely that our patient's hematuria was factitious because results of analysis of urine were otherwise unremarkable and because urine obtained by catheterization never contained blood.

Factitious fever is also a well-documented syndrome, with a prevalence of 2% to 9% in patients with fever of unknown origin in several large series.<sup>3-5,12,13</sup> Factitious fever may be produced by various methods of thermometer manipulation or by self-injection of contaminated or pyrogenic substances. Thermometer manipulation results in the apparent loss of normal diurnal temperature variation and is unaccompanied by skin warmth, tachycardia, diaphoresis and leukocytosis when thermometer readings are elevated. Elevated thermometer readings produced by thermometer manipulation may differ greatly from temperature readings obtained with a nurse or physician in constant attendance, or from different body orifices, leading to the appearance of widely and rapidly fluctuating thermometer readings.<sup>3,5</sup> Our patient's temperature readings were taken in the presence of hospital staff but were unaccompanied by tachycardia or leukocytosis. His fevers may have been a physiologic response to the injection of foreign, contaminated material; on the other hand, fever in the setting of another factitious illness is often itself factitious, and patients with self-induced infections have been known to manipulate their thermometers.<sup>4,5</sup>

In two recent reports, self-induced infections accounted for 41% of cases of factitious fever<sup>5</sup> and 30% of all cases of factitious disorders.<sup>2</sup> The most frequent clinical presentations of self-induced infections are chronic recurrent subcutaneous abscesses and bacteremias. A pattern of several infections over many years is usual before the factitious cause is recognized. Self-injection from syringes filled with contaminated substances is a common method of inoculation, and Gram-negative enteric organisms and Gram-positive cocci are the usual pathogens. Most self-induced infections are simultaneously or consecutively polymicrobial unless pure bacterial cultures are injected.<sup>5,13</sup> Other materials that have been injected include air, dirt, saliva, human and animal feces, foot washings, tetanus toxoid, milk, deodorant, alcohol and lighter fluid.<sup>4,5,13</sup> Our computerized search of the medical literature failed to find published reports of the self-administration or effects of oral antacid preparations given parenterally. Furthermore, we found only two cases of *C albicans* fungemia associated with self-induced infection.<sup>5,13</sup> Both were associated with cases of polymicrobial bacteremia, and one was felt to be due to a contaminated intravenous catheter.<sup>5</sup> Although *Candida* endocarditis has been described in intravenous drug abusers, *C albicans* fungemia associated with infected urinary or intravenous catheters may resolve spontaneously in immunocompetent hosts following catheter removal.<sup>14</sup> After we removed the contaminated vial and syringes from the bedside, blood cultures for *C albicans* were persistently negative and the patient had a benign clinical course, indicating that neither endocarditis nor disseminated tissue invasion was present.

### Psychopathology

Psychiatrically, patients with factitious disorders are a heterogeneous group with diagnoses including neurosis, per-

sonality disorders, organic mental states and psychosis.<sup>15</sup> Some have borderline personality disorder, which is characterized by intense anger and depression, impulsive self-destructive behavior, unstable relationships with others (including physicians) and brief episodes of psychosis.<sup>5,16</sup> Patients with factitious disorders may have a history of early rejection or abandonment by their parents or early exposure to chronic illness, physicians or institutional care. They also may have education or experience in medically related areas and real or imagined physical abnormalities. For some of these patients, admission to hospital and care by physicians and nurses may represent an unconscious reenactment of disturbances in early relationships with parents over issues of trust, dependency, mastery, aggression and guilt.<sup>17,18</sup>

Some patients produce only one or occasional factitious disorders in response to stress and have no other evidence of psychiatric impairment. Others with a variant of factitious disorder termed Munchausen's syndrome have a history of drug abuse and sociopathic, criminal or psychotic behavior that is obscured by their gross impostures and pathological lying.<sup>15-18</sup> Although pain control is often an issue, they readily accept painful invasive procedures. These patients travel widely, simulate abdominal, hemorrhagic or other emergencies and may leave a hospital abruptly following a hostile confrontation with their physicians. Our patient's history of drug abuse and imposture and his hostile, noncompliant response to psychiatric hospital admission suggest that he belongs in this Munchausen's syndrome subgroup. Patients with another variant of factitious disorder have been described as immature, passive and hypochondriacal.<sup>2,4</sup> These patients are more likely to be young women and to have worked or trained in a medically related field. They are also more likely to respond favorably to confrontation and ongoing medical or psychiatric care. Patients in any of these groups may present with severe or life-threatening factitious disorders.

### Diagnosis

Patients with factitious disorders usually present unduly long, complex or improbable histories filled with medical or pseudomedical terminology. Early recognition of these disorders, therefore, requires that historical or other inconsistencies be clarified as they arise. Other hospitals and physicians, insurance companies, employers or relatives may also provide useful diagnostic information. Once a factitious disorder is suspected, the patient should be observed carefully for behavior confirming this diagnosis. Occasionally, as in the case reported here, materials used to produce the factitious disorder may be discovered. When enough evidence to suggest the diagnosis has been gathered, the patient should be confronted in a supportive and nonthreatening manner, without implying abandonment by the primary physician.<sup>2,5,13,16</sup> Plans for continued medical and psychiatric treatment should be presented to the patient at the time of confrontation. Although confrontation rarely results in confession, even when the evidence is convincing, it may relieve an impasse between the patient and the medical staff or result in disappearance of the factitious disease. A few patients make their deception so obvious that they seem to invite confrontation and leave the hospital angrily after a short stay. In others, confrontation may lead to further self-destructive be-

havior or flight from treatment.<sup>8</sup> A psychiatric consultant may help to identify patients at high risk for reacting poorly to confrontation and may also assist with the confrontation process.

### Treatment

The patient in the case reported here may have accepted psychiatric treatment as a condition of continued hospital stay. Most patients with factitious disorders are resistant to psychiatric intervention, however, and no psychiatric treatment approaches have proved consistently effective.<sup>15,16</sup> Many of these patients are also unable to maintain a therapeutic relationship with a primary care physician, and their long-term medical care is often fragmented and episodic. Patients who are willing to be followed in a primary care setting should be given careful medical evaluations, and those who are overly concerned about a real or imagined physical abnormality should be reassured. A schedule of regular outpatient visits should then be established.<sup>19</sup> This schedule relieves the patient's fears of abandonment by the physician and removes the contingency of further visits on the presence of disease. During the actual visits, a supportive, noninterpretive approach should be taken and healthy psychosocial behaviors such as appropriate recognition and expression of feelings should be reinforced by the physician's interest and approval. Formal contracts may be used to limit the use of medications, procedures and visits to other physicians and the production of factitious disease. For patients with borderline personality disorder, unrealistic expectations for care and dramatic responses to disappointment should be anticipated.<sup>5,16</sup> Because borderline patients frequently characterize others as "all good" or "all bad," physicians and staff must agree on a consistent treatment approach. It must be emphasized that patients with factitious disorders are poorly understood and that many are incorrigible or present major treatment problems. Physicians who expect patients to become cured, insightful or grateful will need to lower these expectations to avoid anger and disappointment.

A key aspect of treatment is avoiding negative attitudes toward the patient. Although these patients intentionally mislead or manipulate physicians, many regard physicians as allies and do not derive pleasure from deceiving them. Physicians should thus regard the production of factitious disease as an emotional disorder rather than malicious trickery.<sup>2,10</sup> Anger at the patient may result in an exaggerated attitude of mistrust, neglect of coexistent medical problems or outright abandonment. Similarly, guilt related to missing the diagnosis, accusing the patient of lying or feeling helpless may result in an intense or exclusive focus on medical or surgical problems and neglect of pertinent psychosocial issues.<sup>16</sup> Discussing the case with a psychiatrist may help the primary physician exclude other psychiatric disorders and plan an

effective management strategy. Although the prognosis for the disappearance of a factitious disorder is guarded for patients with psychosis or borderline personality disorder, patients with good premorbid psychosocial function may recover and have no further factitious episodes.<sup>2</sup>

The diagnosis and management of factitious disorders pose some unique legal and ethical questions.<sup>20</sup> Failing to initiate appropriate emergency care until a true pathophysiologic state is ruled out, circulating photographs of a patient to other physicians or suddenly abandoning a patient may be grounds for a lawsuit. Searching a patient's belongings for evidence of factitious disease without his or her knowledge or consent has been justified on the basis of suicidal risk<sup>2</sup>; however, few of these patients have been successfully committed to psychiatric institutions as a danger to themselves.<sup>15</sup> Finally, the physician's duty to protect a patient's integrity and confidentiality is challenged by the deceit and may conflict with the physician's duty to inform affected family members, other physicians and third-party payers of the factitious nature of the disorder.

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